Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HIGHPOINT PHARMACY
5500 EAST LOOP 820 SOUTH #102
FORT WORTH TX 76119

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

AMERICAN HOME ASSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-03-8935-01

MFDR Date Received

JULY 28, 2003

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The disputed issue is that the Carrier has denied some of the claims stating not treating doctor and they have not provided us with an explanation of benefits for other claims. We resubmitted the claims to the Carrier for reconsideration via certified mail. The Carrier received and signed for the reconsideration request on March 10, 2003. To date we have not received a response to the reconsideration request nor have they provided the explanation of benefits for the other outstanding dates."

Amount in Dispute: $2,638.12

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines. All reductions of the disputed charges were made appropriately."

Response Submitted by: Flahive, Ogden & Latson, PO Drawer 13367, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 31, 2002 August 27, 2002 September 16, 2002 September 26, 2002 September 27, 2002 October 3, 2002 October 21, 2002 October 28, 2002	CELEBREX 200 MG; NDC: 0025152551, 30 Units ZOLOFT 50 MG; NDC: 0049490066, 30 Units HYDROCO/APAP 10/500; NDC: 52544054001, 60 Units CARISOPRODOL 350 MG; NDC: 58809042405, 60 Units DIAZEPAM 10 MG; NDC: 00555016405, 30 Units	$1,380.12	$1,248.27
September 16, 2002	HCPCS Codes E0164 (D0214), E1300 (32" reacher); L0565 LSO back brace; E1399 (sterile gauze); E1399 (D0235) (surgical tape); E1399 (Aloe lotion 8 oz); E1399 (Opsite wound closure); E1399 (Primapore wound dressing); E0141 (D0630 & D642) (walker rigid with wheels)	$1,258.12	$439.36

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Teas Administrative Code §134.503 sets out the reimbursement methodology for prescription medications.
3. 1996 Medical Fee Guidelines, DME Ground Rule, sets out the methodology for durable medical equipment.
4. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
5. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated August 23, 2002, October 9, 2002, October 28, 2002, November 11, 2002, December 5, 2002, and January 23, 2003,
   - L – 1 – Not Treating Doctor

Issues

1. Did the requestor submit the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307?
2. Did the requestor establish that the treating doctor referred this injured worker to Dr. Jacob Rosenstein, MD?
3. Did the requestor bill the prescription medications in accordance with 28 Texas Administrative Code §134.503?
4. Did the requestor bill the durable medical equipment in accordance with the 1996 Medical Fee Guidelines, DME Ground Rule IX(C)?
5. Did the requestor support fair and reasonable in accordance with 28 Texas Administrative Code §134.1?

Findings

1. Review of the request for medical fee dispute resolution finds that the requestor submitted the request in accordance with 28 Texas Administrative Code §133.307 and is eligible for review.
2. The services in dispute were denied as L, 1 – "Not Treating Doctor." The requestor has submitted a letter dated May 31, 2002 referring the injured worker to Dr. Jacob Rosenstein. The requestor also submitted a preauthorization approval, sent to Jacob Rosenstein, MD, for L5-S1 decompression with lateral gutter fusion/pedicle screws & exploration of L4-5 fusion.
3. In accordance with 28 Texas Administrative Code §134.503(a)(1) – (3): The maximum allowable reimbursement (MAR) for prescription drugs shall be the lesser of: (1) The provider's usual and customary charge for the same or similar service; (2) The fees established by the following formulas based on the average wholesale price (AWP) determined by utilizing a nationally recognized pharmaceutical reimbursement system (e.g. Redbook, First Data Bank Services) in effect on the day the prescription drug is dispensed. (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee = MAR; (B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee = MAR; (C) A compounding fee of $15 per compound shall be added for compound drugs; or (3) a negotiated or contract amount.

DATE	MEDICATION	§134.503 (a) (1)	§134.503(a) (2)	MAR is Lesser of (a)(1) & (a)(2), (a)(3) irrelevant because no contract exists	PAID	Additional Due
July 31, 2002	CELEBREX 200 MG NDC: 00025152551 30 Units	Not Supported	$94.02	Cannot be established	$0.00	$94.02

August 27, 2002	CELEBREX 200 MG NDC: 00025152551 30 Units	Not Supported	$94.02	Cannot be established	$0.00	$94.02
July 31, 2002	ZOLOFT 50 MG NDC: 00049490066 30 Units	Not Supported	$86.43	Cannot be established	$0.00	$86.43
August 27, 2002	ZOLOFT 50 MG NDC: 00049490066 30 Units	Not Supported	$86.43	Cannot be established	$0.00	$86.43
September 26, 2002	ZOLOFT 50 MG NDC: 00049490066 30 Units	Not Supported	$86.43	Cannot be established	$0.00	$86.43
September 16, 2002	HYDROCO/APAP 10/500 NDC: 52544054001 60 Units	Not Supported	No price established in Price Alert under NDC number documented	Cannot be established	$0.00	$0.00
September 27, 2002	HYDROCO/APAP 10/500 NDC: 52544054001 60 Units	Not Supported	No price established in Price Alert under NDC number documented	Cannot be established	$0.00	$0.00
October 28, 2002	HYDROCO/APAP 10/500 NDC: 52544054001 60 Units	Not Supported	No price established in Price Alert under NDC number documented	Cannot be established	$0.00	$0.00
September 16, 2002	CARISOPRODOL 350 MG NDC: 58809042405 60 Units	Not Supported	$209.60	Cannot be established	$0.00	$209.60
September 27, 2002	CARISOPRODOL 350 MG NDC: 58809042405 60 Units	Not Supported	$209.60	Cannot be established	$0.00	$209.60
October 28, 2002	CARISOPRODOL 350 MG NDC: 58809042405 60 Units	Not Supported	$209.60	Cannot be established	$0.00	$209.60
September 16, 2002	DIAZEPAM 10 MG NDC: 00555016405 30 Units	Not Supported	$15.36	Cannot be established	$0.00	$15.36
October 3, 2002	DIAZEPAM 10 MG NDC: 00555016405 30 Units	Not Supported	$15.36	Cannot be established	$0.00	$15.36
October 21, 2002	NEXIUM DR 40 MG NDC: 00186504031 30 Units	Not Supported	$141.42	Cannot be established	$0.00	$141.42
						$1,248.27

4. In accordance with the 1996 Medical Fee Guideline DME Ground Rule IX(C) the provider shall use the HCFA-1500 Form for billing. Invoices should be billed at the provider's usual and customary rate. Reimbursement shall be an amount pre-negotiated between the provider and carrier or if there is o pre-negotiated amount, the fair and reasonable rate. A fair and reasonable reimburse shall be the same as the fee set for the "D" codes in the 1991 Medical Fee Guideline.
    - HCPCS Code E0164 (D0214) – Mobile commode with fixed arms. Requestor billed $315.00; the 1991 Medical Fee Guideline priced this code at $315.00; therefore, reimbursement is recommended.
    - HCPCS Code E1399 (D0325) – Surgical Tape. Requestor billed $5.00; the 1991 Medical Fee Guideline priced this code at $18.33 per roll; therefore, reimbursement is recommended.
    - HCPCS Code E0141 (D0630 & D0642) – Walker rigid with wheels. The 1991 Medical Fee Guideline priced these codes at $74.40 for HCPCS Code D0630 (Walker, rigid) and $44.96 for HCPCS Code D0642 (Walker (rigid) wheel attachment for a total of $119.36, the amount in dispute. Therefore, reimbursement is recommended.
5. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission." The requestor billed the following HCPCS codes that under the 1996 Medical Fee Guideline Durable Medical Equipment Ground Rules have no fee assigned. Therefore, the equipment and supplies billed by the requestor will be reviewed for fair and reasonable reimbursement:
    - HCPCS Code E1399 – 32" reacher.
    - HCPCS Code L0565 LSO back brace
    - HCPCS Code E1399 – Sterile gauze 4 x 4 #10
    - HCPCS Code E1399 – Aloe lotion 8 oz.
    - HCPCS Code E1399 Opsite wound closure 14.75 x 4.75 #7
    - HCPCS Code E1399 – Primapore wound dressing 11.75 x 4 $14

    In support of the requested reimbursement, the requestor submitted redacted explanations of benefits, and selected portions of EOBs, from various sample insurance carriers. However, the requestor did not discuss or explain how the sample EOBs support the requestor's position that additional payment is due. Review of the submitted documentation finds that the requestor did not establish that the sample EOBs are for services that are substantially similar to the services in dispute. The carriers' reimbursement methodologies are not described on the EOBs. Nor did the requestor explain or discuss the sample carriers' methodologies or how the payment amount was determined for each sample EOB. The requestor did not discuss whether such payment was typical for such services or for the services in dispute. The request for reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Payment cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $1,687.63.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,687.63 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 15, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.